Client Referral Form

Fax completed form to Central Scheduling at 914-347-8859

MHA The Mental Health Association of Westchester

Are you a returning client?	☐ Yes ☐ No	**Today's Date**		**Preferred Name**	
Last Name		**First Name**		**Sex on Insurance**	☐ Female ☐ Male
Gender Identity	☐ Female ☐ Transgender Woman/Female ☐ Male ☐ Transgender Man/Male ☐ Other ☐ Choose Not To Disclose	**Sexual Orientation**	☐ Bisexual ☐ Choose Not To Disclose ☐ Does Not Know ☐ Lesbian, Gay, or Homosexual ☐ Other ☐ Straight or Heterosexual		
Date of Birth	Month Day Year	**Social Security #**			

Do you have insurance?	☐ Yes ☐ No	**Relationship to Insured**	
Insurance		**ID/Policy #**	
		Medicaid # (if applicable)	
Additional Insurance		**ID/Policy #**	
		Medicaid # (if applicable)	
If different from client, please provide the information below.			
Insured Name			
Date of Birth	Month Day Year	**Social Security #**	

Your answers to the following questions will help us reach you quickly and discreetly with important information.			
Mobile Phone		☐ OK to Leave Message – Mobile Phone	
Other Phone		☐ OK to Leave Message – Other Phone	
Email Address		☐ Email is Shared	
Preferred Contact Method (Please choose 1)	☐ Mobile Phone ☐ Other Phone ☐ Email ☐ Text		
Address	Street City State Zip Code		
Type of Residence	☐ Private Residence ☐ Incarcerated ☐ DSS/ACS Agency Boarding/Foster Home ☐ Nursing Home or Health-Related Facility ☐ Homeless (Shelter/Street/Transitional Living Center) ☐ Other:		

Referral Source (Organization)		**Referral Contact (Person)**	
Primary Reason for Referral		**Initial Contact Method (How did you hear about us?)**	
Referral Source Address			
Referral Contact Phone #		**Email**	

If applicable, please fill out the hospital referral information below.			
Recently Hospitalized	☐ Yes ☐ No	**COPS Referral (Hospital Inpatient)**	☐ Yes ☐ No
Hospital		**Discharge Date**	
Discharge Paperwork Sent	☐ Yes ☐ No *If no, when will it be sent:*	**Next Due Date**	
Receiving Injectable Medication		☐ Yes ☐ No	
Injectable Medication/Dosage			

If client is a minor, please provide the information below.			
Parent/Guardian Name		**Phone #**	
Address	Street City State Zip Code		
Preferred Language (if other than English)			

Emergency Contact		Phone #	
Address	Street	City	State	Zip Code

Please select a service location.

☐ **White Plains** 300 Hamilton Ave- Suite 201 White Plains, NY 10601	☐ **Mt Kisco** 344 Main Street- Suite 301 Mt Kisco, NY 10549	☐ **Yonkers/OnTrack NY** 20 South Broadway- Suite 402 Yonkers, NY 10701	☐ **Upper Nyack** 311 N. Midland Ave- Suite #3 Nyack, NY 10960
☐ **IOP** 29 Sterling Place White Plains, NY 10601	☐ **Haverstraw** 20 George Street Haverstraw, NY 10927	☐ **Nyack- BOCES** 131 Midland Avenue North Nyack, NY 10960	

For school referrals only

☐ **Fieldstone Middle School** 100 Fieldstone Drive, Thiells, NY 10984	☐ **North Rockland High School** 106 Hammond Road, Thiells, NY 10984	☐ **NR High School Extension** 63 Chapel Street, Garnerville, NY 10923

This information is for demographic purposes only and will not affect your care.

Race	☐ White ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Other Race ☐ Decline To Provide Race	**Ethnicity**	☐ Hispanic or Latino ☐ Decline to Provide Ethnicity ☐ Not Hispanic of Latino
		Ethnicity Detail	☐ Cuban ☐ Mexican/Mexican American/Chicano(a) ☐ Dominican ☐ Other Hispanic ☐ Ecuadorian ☐ Puerto Rican

Preferred Language		**Secondary Language**	
Special Communication Needs	☐ None Reported ☐ Language Interpreter Services ☐ Other ☐ TDD/TTY Device ☐ Sign Language Interpreter Describe:		
Special Physical Accommodations (If yes, please describe)			

Veteran	☐ Yes ☐ No	**Active Duty**	☐ Yes ☐ No	**Discharge Status**	☐ Dishonorable ☐ Honorable ☐ General ☐ N/A	**Other**	☐ Disabled Veteran ☐ VA Services Eligible ☐ Veteran Family Member

Please check all that apply.

☐ Criminal History	☐ Suicide Risk	☐ Recent Discharge from Psych or SUD Treatment
☐ Parole/Probation	☐ AOT	☐ Chronic Health Conditions:
☐ Sex Offender	☐ Eating Disorder	☐ Co-Occurring Disorder:
☐ History of Aggression	☐ Medication Assisted Treatment	☐ History or Current SUD:

Please select services you are interested in. If you are enrolled in any of the services below please identify your case worker.

☐ Care Management/Manager:

☐ HCBS Services:

☐ SUD/Credentialed Alcoholism & Substance Abuse Counselor (CASAC):

☐ Peer Outreach:

☐ Family Support:

☐ Employment Services:

To be filled out by MHA Staff.

Program		**Client ID**	
Assigned Clinician		**Self-Pay Assigned**	

Please fax form to (914)347-8859 attention Central Scheduler. Intakes are processed within 24-48 hours of receipt. Due to high call volume we will relay the appointment information to you as soon as possible via phone. Please provide that information where indicated. If this form is incomplete scheduling can be delayed.